NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

EMPLOYEE PRESCRIPTION DRUG PLAN

MEMBER HANDBOOK

Department of the Treasury
Division of Pensions and Benefits

January 2005

Online revision — includes changes for Plan Year 2006

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INTRODUCTION

The State Health Benefits Program (SHBP) was originally established in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 17.25 et.seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP. The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance, the Commissioner of the Department of Personnel, a State employee representative chosen by the Public Employees' Committee of the AFL-CIO, and a representative chosen by the New Jersey Education Association (NJEA), or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

The Employee Prescription Drug Plan provides prescription drug coverage at a designated copayment based upon the type of medication purchased (and if you are a State employee, your union affiliation). Prescription drug services are available through a participating retail pharmacy, a mail order service, and specialty pharmaceutical providers.

The Employee Prescription Drug Plan is administered by Caremark on behalf of Horizon Blue Cross Blue Shield of New Jersey. Caremark is the claims administrator for all eligible members. You may use any licensed pharmacy; however, prescription drugs are available at the designated copayment levels only when a participating pharmacy is used. A prescription drug plan identification card is provided and use of the ID card is required to obtain medications at a participating retail pharmacy for the designated copayment.

An online version of this handbook containing current updates is available for viewing over the Internet at: *www.state.nj.us/treasury/pensions/shbp.htm* Be sure to check the Division of Pensions and Benefits Internet home page at: *www.state.nj.us/treasury/pensions* for SHBP related forms, fact sheets, and news of any new developments affecting the benefits provided under the SHBP.

State law and the New Jersey Administrative Code govern the SHBP. Every effort has been made to ensure the accuracy of the *Employee Prescription Drug Plan Member Handbook*, which describes the benefits provided in the contract with Horizon BCBSNJ. **However, if there are discrepancies between the information presented in this handbook and the law, regulations, or contract, the latter will govern.**

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: *pensions.nj@treas.state.nj.us* Refer to page 27 for information on contacting the SHBP and its related health services.

STATE HEALTH BENEFITS PROGRAM
EMPLOYEE PRESCRIPTION DRUG PLAN

ELIGIBILITY

The **Employee Prescription Drug Plan** is offered to:

- Eligible State of New Jersey employees and their dependents.
- Eligible employees of State colleges and universities and participating independent State commissions, authorities, and agencies and their dependents.
- Eligible employees of local employers and their dependents if the employer has opted for participation in the Employee Prescription Drug Plan.

The Employee Prescription Drug Plan rules of eligibility and information on maintaining coverage are the same as those for the State Health Benefits Program (SHBP) medical plans. Please refer to the *SHBP Summary Program Description* for additional eligibility, enrollment, and coverage information (see page 28 for information on how to obtain this publication).

PLAN BENEFITS

Plan benefits are available through a participating **retail pharmacy,** the plan's designated **mail order service,** or from a participating **specialty pharmaceutical provider**.

RETAIL PHARMACY

Normally, retail pharmacy copayment amounts are for a 30-day supply. However, you may obtain up to a 90-day supply of your prescription drug. To do so, you must pay two copayments for a 31- to 60-day supply or three copayments for a 61- to 90-day supply (see page 3 for copayment information).

MAIL ORDER SERVICE

Mail order benefits are available where participants can receive up to a 90-day supply of prescription drugs for one copayment (see page 3 for copayment information). Additional information about using the mail order service begins on page 5.

SPECIALTY PHARMACEUTICAL PROVIDER

Specialty pharmaceuticals are a class of medications that are typically produced through biotechnology, administered by injection, and/or require special patient monitoring and handling. Examples of prescription drugs that qualify as specialty pharmaceuticals include, but are not limited to, those used to treat the following conditions: Chrohn's Disease; Infertility;

Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; or Gaucher's Disease.

Effective February 15, 2006, specialty pharmaceuticals are provided through Caremark Specialty Pharmacy which is the exclusive provider for specialty pharmaceuticals for the SHBP's Employee Prescription Drug Plan. If your doctor has prescribed a specialty pharmaceutical, you will not be able to fill the prescription at a retail pharmacy and the pharmacy representative will advise you to contact CaremarkConnect at 1-800-237-2767. When calling, identify yourself as a State Health Benefits Program member. Caremark will contact your doctor and take care of the appropriate paperwork. Your medication will be shipped directly to your home, office, or doctor's office.

The retail copayment applies for each 30 day supply of specialty pharmaceuticals.

COPAYMENT AMOUNTS

State Employees — As a result of contract negotiations and the fiscal year 2005 Budget Appropriations Act, most State employees have new prescription drug plan copayment amounts beginning with the 2005 plan year.

The new copayments go into effect for all non-aligned employees of the State and State colleges and universities. The changes also go into effect for State employees and employees of State colleges and universities covered by a collective bargaining agreement, where the agreement provides for such changes. Employees in bargaining units that have not agreed or adopted these changes will not be affected until such time as the majority representative agrees to them, or they are made part of a final and binding interest arbitration award.

The State employees described above pay a:

- $3.00 copayment at a retail pharmacy or specialty pharmaceutical provider for up to a 30-day supply of a generic[1] drug; or
- $10.00 copayment at a retail pharmacy or specialty pharmaceutical provider for up to a 30-day supply of a brand name prescription drug; or
- A mail order copayment of $5.00 for a generic[1] drug or $15.00 for a brand name prescription drug for up to a 90-day supply (see *Mail Order Services* on page 5 for more information).

Employees of a local employer, and State employees covered under the labor agreements that have not agreed to or adopted the changes described above, pay a:

- $1.00 copayment at a retail pharmacy or specialty pharmaceutical provider for up to a 30-day supply of a generic[1] drug; or
- $5.00 copayment at a retail pharmacy or specialty pharmaceutical provider for up to a 30-day supply of a brand name prescription drug; or
- A mail order copayment of $1.00 for a generic[1] drug or $5.00 for a brand name prescription drug for up to a 90-day supply (see *Mail Order Services* on page 5 for more information).

[1]See page 8 for additional information about generic drugs.

PURCHASING YOUR PRESCRIPTION DRUGS AT A PHARMACY

To purchase a prescription drug at a retail pharmacy, present your identification card and prescription to the pharmacist. Prescription drug refills are also covered as long as the prescription is used within one year of the original prescription date, authorized by your physician, and permitted by law.

PARTICIPATING PHARMACIES

If you use a participating pharmacy, you will pay the appropriate copayment for the purchase of up to a 30, 60, or 90-day maximum supply. Almost all New Jersey pharmacies have elected to participate with the Employee Prescription Drug Plan offered through Horizon Blue Cross Blue Shield of New Jersey and administered by Caremark. To identify a participating pharmacy in your area you may contact Caremark, toll free, at 1-866-881-5605 or check on the Internet at: *www.caremark.com.* Once at the Caremark home page, click on Pharmacy Locator.

When using a participating pharmacy, just present your identification card and the appropriate prescription order. The pharmacist will complete all the necessary paperwork and process your prescription as written. The submission of a claim form is not required. You will be asked only to pay the appropriate copayment(s).

If you have forgotten your identification card, or are waiting for a new one, request your pharmacist to enter "StateNJ" as your group number and the employee's Social Security number as your ID number in order to confirm your coverage. Otherwise, you may have to pay the full cost of the prescription drug to the pharmacist. However, you will still be entitled to the benefits of this plan. Simply get an itemized receipt from the pharmacist and forward it along with a claim form to Caremark for reimbursement. Your reimbursement will be based on the participating pharmacy allowance less your copayment (see *How to File a Claim for Reimbursement* below).

NON-PARTICIPATING PHARMACIES

Over 96 percent of the pharmacies in New Jersey and nationwide participate with Caremark. However, some pharmacies in New Jersey and in other states do not have agreements with Caremark and are not part of the Employee Prescription Drug Plan. When using a nonparticipating pharmacy, you will be asked to pay the full cost of the prescription drug to the pharmacist. You then must file a claim for reimbursement with Caremark. Your reimbursement will be based on the participating pharmacy allowance for the cost of the medication less your copayment. **If the non-participating pharmacy charges more than the allowance for a participating pharmacy, you will not be reimbursed for the difference.**

How to File a Claim for Reimbursement

1. If you have to file a claim for reimbursement, obtain an itemized receipt which includes the:
    - Patient's first and last name;
    - Date the prescription was filled;
    - Name and address of the pharmacy;

- National Drug Code number;
- Name of the drug;
- Dosage;
- Prescription number; and
- Cost of the prescription drug.

2. Obtain a *Prescription Reimbursement Claim Form* from your payroll clerk, personnel officer, Human Resources representative, by calling Caremark Member Services at 1-866-881-5605, or at the Caremark Web site at: *www.caremark.com*.
3. Send the completed claim form, along with your itemized receipt, to: Caremark, PO Box 853901, Richardson, TX 75085-3901.

Claims should be filed as soon as possible. The filing deadline is 1 year and 90 days following the end of the calendar year of the dispensing date. Information about claims or coverage can be obtained by calling Caremark Member Services at 1-866-881-5605.

MAIL ORDER SERVICES

The Mail Order Service is designed for participants taking medication on an ongoing basis, such as medication to reduce blood pressure or treat asthma, diabetes, or any chronic health condition. All Mail Order Service prescriptions are filled by registered pharmacists who are available for emergency consultations 24 hours a day, seven days a week by contacting Member Services at 1-866-881-5605.

How the Mail Order Service Works

Mail Order Service is designed for maintenance drugs that you take on a regular basis. When you order by mail, you get larger quantities of medication at one time – up to a 90-day supply for only one copayment per prescription.

If you have an immediate need for your initial prescription, it is suggested that you ask your physician to provide you with two prescriptions, one for a 90-day supply of needed medications plus refills, the second for a 30-day supply of medication. The 30-day prescription should be filled at your local pharmacy for your use while your mail order prescription is being processed.

Note: Certain prescription drugs, including specialty pharmaceuticals, self-administered injectable drugs, and other drugs requiring special handling are not available through the mail order pharmacy and should be obtained from a participating specialty pharmaceutical provider (see page 2). Drugs obtained from retail or specialty providers are subject to a copayment per 30-day supply of medication.

If this is the first time you are using the mail order service, you will need to complete a Patient Profile Questionnaire with your first order. You will receive the questionnaire with your initial prescription drug plan identification card. You may also obtain a questionnaire by contacting Caremark Member Services at 1-866-881-5605. Your Personal Patient Profile data will be stored and referenced each time a new prescription is processed to assure against drug reactions. Be sure to answer all the questions and make certain you include your 9-digit identifica-

tion number on the form. You may also complete this questionnaire to update your existing account information with Caremark.

Mail your prescription along with your completed order form and the appropriate copayment, to the address on the order form. You may pay by Visa, MasterCard, Discover, American Express, or by check or money order. Please do not send cash.

Your mail order prescription is reviewed by a pharmacist, dispensed by the pharmacist, and verified through the Mail Order Service Quality Control Department prior to mailing.

Your order will be processed and your medications will be sent to you in plain, tamper-evident packaging for security and confidentiality via First Class U.S. Mail, UPS, or Federal Express, along with reorder instructions and a postage paid envelope for future prescription drugs and/or refills. Express shipping is available for an additional charge.

Transfer an Existing Prescription

For a fast and easy way to use mail order, call Member Services at 1-866-881-5605. Tell the representative that you would like to transfer your prescription from your retail pharmacy to the Mail Order Service. Have your prescription drug container handy. You will need information off the label along with your medical history and the prescribing physician's name and telephone number. Your Mail Order Service pharmacist will contact your doctor to authorize a new prescription on your behalf. Your prescription will then be promptly filled, and your medication will arrive at your home within 14 days.

New Prescriptions Submitted by Phone from Your Doctor

You can ask your doctor to call Caremark's provider line at 1-877-278-0347 to order a new prescription through the Mail Order Service. *Please note: this phone number is for physicians only and is not to be used by patients.*

You may choose to have your doctor fax your new prescription directly to Caremark at 1-877-278-0328. To obtain a physician fax form on behalf of your doctor, call Caremark Member Services at 1-866-881-5605. Caremark cannot accept faxes from members.

New Prescriptions Submitted by Phone from the Member

You can request a new prescription — provided that you have obtained the actual prescription from your physician — over the phone through the FastStart Service, toll-free at 1-866-772-9414. Provide the FastStart representative with the following information:

- Member ID number (on your prescription benefit card);
- Medication name;
- Prescribing doctor's name and phone number;
- Shipping address; and
- Credit card number and expiration date.

The representative will contact your doctor to complete the order.

Online Access

The Mail Order Service is available over the Internet at: *www.caremark.com* where you can:

- Refill your Mail Order Service prescriptions.
- Check the status of a refill order.
- Obtain Mail Order Service forms.

Obtaining Refills Through the Mail Order Service

To help ensure you never run short of your prescription medication, you should reorder when you have 14 days of medication left. The proper copayment amount will be billed to the credit card on file with Caremark.

There are three ways to order refills:

By Mail: — With your original prescription medication, you will receive a pre-addressed envelope and a notice showing the number of times it may be refilled. Mail this refill notice with your copayment to Caremark in the envelope provided.

By Telephone: — Simply call Member Services at 1-866-881-5605, 24 hours a day, 7 days a week. Have your refill slip with your prescription information ready. Use the simple voice instructions to enter your member ID number and the 7-digit prescription number of the medication that you are requesting. Your prescription medication will be sent to your home.

Over the Internet: — If you have Internet access, you may refill your prescription online. Go to the Caremark Web site at: *www.caremark.com* Click the link that says "Refill a Prescription." Enter your login information (preregistration is required) and the prescription number of your medication. You will see a detailed summary of your order, including costs. Review the information and then click on the shopping cart next to the medication to refill your prescription.

Note: Prescriptions for perishable drugs and those sensitive to heat and cold should be processed at a participating pharmacy nearest your home. If processed through the Mail Order Service, you will be advised prior to shipment of the mailing date to ensure someone is home to receive the delivery.

INFORMATION ABOUT GENERIC DRUGS

What are Generic Drugs?

In many instances, consumers have a choice between brand name drugs and generic drugs. A brand name drug is a medication manufactured by a drug company that has developed and patented the drug. After the drug patent expires, other manufacturers who can meet the FDA production standards may produce and market an equivalent product. These medications, known as generic drugs, are chemically and therapeutically equivalent to their brand name counterparts.

Substitution of drugs in New Jersey is regulated by law. The law stipulates that when a physician indicates "substitution permissible" or gives no indication at all on the prescription, the pharmacist must substitute a generic drug, unless otherwise advised by the patient or prescribing physician that substitution is not permissible.

Who Determines if a Participant can Receive Generic Drugs?

Your physician determines whether a brand name or generic product is dispensed to you. You can take full advantage of the savings offered by the Employee Prescription Drug Plan by asking your physician to prescribe a generic drug or write a prescription which allows substitution of a generic drug whenever it is legally permissible.

If your physician writes a prescription that allows only for a brand name drug, the pharmacist will be required to dispense that drug, and you will be required to pay the appropriate higher copayment. So, if you are interested in the savings, be sure to inform your physician of your choice of a generic substitute when he or she is prescribing medications for you and your family.

COVERAGE AND SERVICES PROVIDED BY THE EMPLOYEE PRESCRIPTION DRUG PLAN

Your Employee Prescription Drug Plan helps meet the cost of drugs prescribed for you and your covered dependents for use outside of hospitals, nursing homes, or other institutions. As required by Federal Law, covered drugs can be dispensed only upon a written prescription ordered by a physician.

The following are covered benefits unless listed as an exclusion:

- Federal legend drugs.
- Compounded medications.
- Insulin.
- Oral and injectable contraceptives and contraceptive patches.
- Infertility drugs.
- Over-the-counter diabetic supplies, including test kits and test strips.
- Disposable needles and syringes for diabetic use only.

Dispensing Limits

The maximum amount of a drug which is allowed to be dispensed per prescription or refill:

- **Retail Pharmacy** — up to a 90-day supply.
- **Mail Order Service** — up to a 90-day supply.

Prescription drugs are not eligible to be refilled until 75 percent of the last ordered and dispensed supply period has passed. (ie. a refill for a 30-day supply will be honored after 23 days have passed.)

The State Health Benefits Commission reserves the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, and the Specialty Pharmacy Program may be employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions currently apply to certain drugs such as sexual dysfunction drugs (Viagra, Muse, etc.).

Utilization Management

The Employee Prescription Drug Plan includes various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, plan members benefit by obtaining appropriate prescription drugs in a cost-effective manner. Among the programs utilized are the following.

- **Dispensing Quantity Limit** — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- Lower-priced clinical alternatives available.
- FDA-approved dosing regimen(s).

- **Step Therapy** — Step Therapy encourages a trial of less costly first-line prescription drugs before the use of more costly second line agents. Second line agents are new medications that come on the market. The new medications are determined by the Food and Drug Administration (FDA) to be effective, but not more effective than the medications already on the market.
- **Dose Optimization Program** — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.
- **Prior Authorization** — A mechanism to screen a drug class by specific criteria along with a patient's medical history to determine if the drug is covered under the plan. Prior authorization must be obtained for specific prescription drugs before they are determined to meet the eligibility requirements of the plan.
- **Member Utilization Management Program** — Pharmacy claims (along with supporting medical data) are evaluated on a periodic basis to identify, document, and correct or deter cases of excessive or abusive utilization. The program may also identify members who are candidates for case management.

Under certain circumstances, a pharmacy may not be able to determine at the point of sale, whether a prescription drug is covered. For example, the information on the prescription order may not be sufficient to determine medical necessity and appropriateness. In those circumstances, a member may elect to receive a 96-hour supply of the prescription drug, as a covered benefit, until the determination is made. Alternatively, the member may decide to purchase the prescription drug and submit a claim for benefits. If the claim is denied, no charge in excess of the charge for the 96-hour supply will be covered for that prescription drug or any refill(s) of it.

WHAT THE EMPLOYEE PRESCRIPTION DRUG PLAN DOES NOT COVER

The following services or supplies are not covered under this plan:

- Non-Federal Legend Drugs.
- State Restricted Drugs.
- Contraceptive jellies, creams, foams, devices, diaphragms, or implants.
- Coinsurance or copayments from another prescription plan.
- Coordination of benefits with prescription and medical plans.
- Needles and Syringes (except for diabetic use).
- Oral agents for controlling blood sugar that do not require a prescription.
- Therapeutic devices or appliances including hypodermic needles, syringes, support garments, and other non-medical supplies.
- Immunizing agents, vaccines, and biological sera.
- Blood, blood products, or blood plasma.
- Drugs dispensed or administered in an outpatient setting, including but not limited to, outpatient hospital facilities and physician offices.
- Drugs dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanitarium, convalescent hospital, or similar facility.
- Infusion drugs and drugs that are administered intravenously (IV), except those that are self administered subcutaneously or intramuscularly.
- Drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by another Drug or Medical Service for which no charge is made to the member.
- Drugs prescribed for experimental or investigational indications.
- Drugs supplied in Unit Dose packaging except when that is the only form distributed to pharmacies.
- Drugs dispensed by an unlicensed pharmacy.
- Prescription drugs which lack U.S. Food and Drug Administration (FDA) approval, or which are approved but prescribed for other than a FDA approved use, or in a dosage other than that approved by the FDA.
- Prescription drugs which do not meet medical necessity and appropriateness criteria.
- "Over-the-counter" drugs, or drugs that do not require a prescription written by a licensed practitioner.
- Professional charges in connection with administering, injecting, or dispensing of drugs.
- Durable medical equipment, devices, appliances, and supplies, even if prescribed by a physician, except prescription contraceptive diaphragms.

- Prescription drugs used primarily for cosmetic purposes.
- Prescription drugs for the treatment of erectile dysfunction in excess of the monthly quantity limit.
- Prescription drugs to enhance normal functions such as growth hormones for antiaging, steroids to improve athletic performance, or memory enhancing drugs, unless medically necessary.
- Cosmetics and health or beauty aids.
- Drugs for weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diet plans, or any related products.
- Select classes of drugs where non-preferred medications that have therapeutic alternatives have shown no added benefit regarding efficacy or side effects over preferred drugs.
- Herbal, nutritional, and dietary supplements.
- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent, except insulin.
- Quantities in excess of dispensing limits.
- Early refills, i.e. a refill of a prescription drug at a retail pharmacy before 75 percent of the last ordered and dispensed supply period has passed.(72 percent for mail order).

ENROLLING IN THE EMPLOYEE PRESCRIPTION DRUG PLAN

Levels of Coverage

You may enroll under one of the following levels of prescription drug coverage:

- **Single** — coverage for yourself only.
- **Member/Spouse or Domestic Partner**[1] — coverage for you and your spouse or eligible same-sex domestic partner only.
- **Family** — coverage for you, your spouse or eligible same-sex domestic partner[1], and eligible children.
- **Parent and Child**(ren) — coverage for you and your eligible children (but not your spouse, if married, or a domestic partner).

When you enroll in the Prescription Drug Plan you will be mailed identification cards.

When Coverage Begins

For all eligible employees, coverage for you and your dependents generally begins on the same date as your health plan coverage. Please refer to the *SHBP Summary Program Description* for additional eligibility, enrollment, and coverage information (see page 28 for information on how to obtain this publication).

If you are an employee of a local government or education employer and your employer opted to participate in the Employee Prescription Drug Plan at a later date than their initial participation in the SHBP for health coverage, your effective date of prescription drug coverage for you and your dependents will begin as of the date your employer commenced participation in the Employee Prescription Drug Plan.

Transfer of Employment

If you transfer from one SHBP-eligible employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that you:

- are still enrolled by the SHBP (COBRA, State part-time, and part-time faculty coverage excluded) when you begin in your new position; **and**
- transfer from one participating employer to another; **and**
- file a new *NJ State Health Benefits Program Application* listing the former employer in the appropriate section of the application.

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[1]Domestic Partner coverage is available to State employees and to Local/Educational employees whose employer participates in the SHBP Employee Prescription Drug Plan **and** has adopted a resolution to participate in Chapter 246, P.L. 2003, the Domestic Partnership Act. A domestic partner is defined for eligibility in the SHBP, as a person of the same sex with whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for more information).

Leave of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness.
- Approved leave of absence other than illness.
- Family Leave Act (federal and State).
- Furlough.
- Workers' Compensation.
- Suspension (COBRA continuation only — see page 15).

When you take an approved leave of absence, you may reduce your level of coverage (for financial reasons) and increase it again when you return from leave. When you return to work, your benefits and those of your eligible family members are reinstated upon completion of a *NJ State Health Benefits Program Application.* Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence. When the leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of enrolling for benefits under the provisions of COBRA (see page 15).

When Coverage Ends

Coverage for you and your dependents will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- Your hours are reduced so you no longer qualify for coverage;
- You do not make required premium payments;
- You enter the Armed Forces and are eligible for government-sponsored health services;
- Your employer ceases to participate in the SHBP; or
- The SHBP is discontinued.

Coverage for your dependents will end if:

- Your coverage ceases for any of the reasons listed above;
- You die (dependent coverage terminates the 1st day of the pay period following the date of death of State employees paid through the State's Centralized Payroll Unit, or the 1st of the month following the date of death for all other employees) ;
- Your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a same-sex domestic partnership; children marry, enter into a domestic partnership, move out of the household, or turn age 23 unless the dependent child qualifies for continuance of coverage due to disability (see *SHBP Summary Program Description* for details); or
- Your enrolled dependent enters the Armed Forces.

If your membership in the Employee Prescription Drug Plan ends, you may be eligible to continue in the Employee Prescription Drug Plan for a limited period of time under the provisions of the federal COBRA law (see page 15). You cannot convert membership to a private plan.

COBRA COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see Duration of Coverage below), and the member must pay the full cost of the coverage plus an administrative fee.

Note: If you are retiring and will be enrolling in the Retired Group of the SHBP, your coverage will include a prescription drug benefit.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

A member may elect to enroll in any or all of the coverages the member had as an active employee or dependent (health, prescription drug, dental, and vision), and may change his or her health or dental plan when enrolling in COBRA. Members may also elect to cover the same dependents that were covered while an active employee, or delete dependents from coverage — the member cannot, however, add dependents who were not covered while an employee except during the annual Open Enrollment period or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the employee.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of same-sex domestic partnership (makes spouse or same-sex domestic partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, or marriage.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your **death, divorce, dissolution of a same-sex domestic partnership,** or he or she becomes ineligible for continued group coverage because of **marriage, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage.**

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

- Your eligibility period expires;
- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP; or
- You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled in the SHBP;
- Notify you, your spouse or eligible same-sex domestic partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the SHBP within 30 days of the loss of an employee’s coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and/or your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits

Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a same-sex domestic partnership, or your death has occurred, or that your child has married, entered into a domestic partnership, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;

- File a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

- First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not continue coverage under COBRA for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Additional Information About COBRA

Additional information about COBRA benefits can be found in the the *SHBP Summary Program Description* (see page 28 for information on how to obtain this publication).

APPENDIX I

CLAIM APPEAL PROCEDURES

If you believe an error has been made in processing your prescription drug claim you may call Caremark Member Services at 1-866-881-5605, or write to:

Caremark
NJ State Health Benefits Program Appeals Coordinator
1300 East Campbell Road, Mail Code 512
Richardson, Texas 75081

Please include the following information in your letter:

- Names and addresses of patient and employee;
- Your prescription drug plan identification number (Social Security number);
- Your group number and group name as shown on your ID card;
- Employer's name;
- Payment voucher number and date;
- Claim number, if available;
- Date the prescription was filled;
- Pharmacy's name;
- Name of the medication;
- Strength of the medication;
- Quantity prescribed;
- Prescription number;
- Amount billed; and
- Amount you paid.

If your drug claim has been denied and you think the claim should be reconsidered, appeals must be made within 12 months of the date you were first notified of the action being taken to deny your claim. When your appeal is received, the claim will be researched and reviewed. Caremark will notify you in writing of the decision on your appeal within 60 days after the appeal is received. Special circumstances, such as delays by you or the provider in submitting necessary information, may require an extension of this 60-day period. The decision on the review will include the specific reason(s) for the decision and refer to specific provisions of the plan on which the decision is based.

After you have exhausted the Caremark internal appeal process, if still dissatisfied with the decision, you or your legal representative may appeal, in writing, to the State Health Benefits Commission. A request for consideration must include the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed in the denial letter from the Commission of further steps (s)he may take.

HIPAA PRIVACY

The SHBP Employee Prescription Drug Plan makes every effort to safeguard the health information of its members and complies with the privacy provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires health plans to maintain the privacy of any personal information relating to its members' physical or mental health. See Appendix III (on page 23) for the State Health Benefits Program's *Notice of Privacy Practices.*

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate, *Affidavit of Domestic Partnership,* or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of the dependent's coverage. If expenses were paid to ineligible dependents, you must make reimbursement to the plan.

APPENDIX II

GLOSSARY

This section defines certain important terms that relate to the SHBP and the Employee Prescription Drug Plan.

Caremark — The pharmaceutical benefits management company that administers the Employee Prescription Drug Plan.

Copayment — The amount charged to the eligible member by a retail pharmacy or the Caremark mail order pharmacy for each prescription drug order or authorized refill.

Dependents — Your eligible dependents are your spouse or an eligible same-sex domestic partner (see page 13) and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.)

If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Dispensing Quantity Limit — A dispensing or quantity limit is the maximum amount of one medication you may receive at one time. Prescription drugs may have a limit for any of the following reasons:

- Safety.
- Clinical guidelines and prescribing patterns.
- Potential for inappropriate use.
- Lower-priced clinical alternatives available.
- FDA-approved dosing regimen(s).

Domestic Partner — Domestic partner SHBP coverage is only available to State employees/retirees and to Local/Educational employees/retirees whose employer has adopted a resolution to participate in health benefits coverage under Chapter 246, P.L. 2003, the Domestic Partnership Act. Under the Act, a domestic partner is defined for SHBP eligibility as a person of the same sex with whom the employee or retiree has entered into a domestic partnership by registering with the local registrar and receiving a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for more information).

Dose Optimization — A drug utilization management process encouraging safe and appropriate use of once-per-day medications. Prescriptions are reviewed for multiple daily drug

doses of a lower strength medication where a higher strength, once daily dose is equally effective. Dose optimization limits are applied to the number of pills per day for certain medications, where the use of multiple pills to achieve a daily dose is not supported by medical necessity.

Drug Utilization Review (DUR) — Drug utilization reviews are performed by Caremark to determine a prescription's suitability in light of the patient's health, drug history, drug-to-drug interactions, and drug contraindications.

Federal Legend Drug — A drug that, by law, can be obtained only by prescription and bears the label, "Caution: Federal law prohibits dispensing without a prescription."

Mail Order Prescription — A prescription which is dispensed by the SHBP designated mail order pharmacy.

Medical Necessity and Appropriateness — Medical necessity and appropriateness criteria and guidelines are established and approved by the Pharmacy and Therapeutics Committee, which consists of practicing physicians and pharmacists. Eligible prescription drugs must meet federal Food and Drug Administration (FDA) approved indications and be safe and effective for their intended use. Drugs administered by a medical professional are not eligible under this plan.

A prescription drug is medically necessary and appropriate if, as recommended by the treating practitioner and as determined by Horizon BCBSNJ's medical director or designee(s) it is all of the following:

- A health intervention for the purpose of treating a medical condition;
- The most appropriate intervention, considering potential benefits and harms to the patient;
- Known to be effective in improving health outcomes (For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence; then if necessary, by professional standards; then, if necessary, by expert opinion);
- Cost effective for the applicable condition, compared to alternative interventions, including no intervention. "Cost effective" does not mean lowest price.

The fact that an attending practitioner prescribes, orders, recommends, or approves the intervention, or length of treatment time, does not make the intervention "medically necessary and appropriate."

National Drug Code Number (NDC) — A universal drug identification number assigned by the Food and Drug Administration (FDA).

Non-federal Legend Drug — A drug that does not require a prescription and is available "over-the-counter."

Non-participating Pharmacy — Any pharmacy that does not have an agreement with Caremark or Horizon Blue Cross Blue Shield of New Jersey.

Participating Pharmacy — Any pharmacy which has entered into an agreement with Caremark or Horizon Blue Cross Blue Shield of New Jersey.

Participating Pharmacy Allowance — The maximum amount a retail pharmacy will be reimbursed by Caremark for a particular medication. The participating pharmacy allowance is specified in the contract participating pharmacies enter into with Caremark.

Pharmacist — A person licensed to practice the profession of pharmacy and who practices in a pharmacy.

Pharmacy — Any place of business which meets these conditions: 1) It is registered as a pharmacy with the appropriate state licensing agency and 2) prescription drugs are compounded and dispensed by a pharmacist. This definition does not include a physician who dispenses drugs, pharmacies or drug centers maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group. It also does not include pharmacies maintained by hospitals, nursing homes, or similar institutions.

Prescription — The request for drugs issued by a physician licensed to make the request in the course of his professional practice.

Prior Authorization — A mechanism to screen a drug/drug class by specific criteria along with a patient's medical history to determine if the drug is covered under the plan. Prior authorization must be obtained for specific prescription drugs before they are determined to meet the eligibility requirements of the plan.

Public Employer — A federal, state, county, or municipal government, authority, or agency; a local board of education; or a state or county university or college.

Specialty Pharmaceuticals — Oral or injectable drugs that have unique production, administration, or distribution requirements. They require specialized patient education prior to use and ongoing patient assistance while undergoing treatment.

Specialty Pharmaceutical Provider — A provider that dispenses Specialty Pharmaceuticals.

State Health Benefits Commission (Commission) — The entity created by N.J.S.A. 52:14-17.27 and charged with the responsibility of establishing and overseeing the State Health Benefits Program.

State Health Benefits Program (SHBP) — The SHBP was originally established by statute in 1961. It offers medical, prescription drug, and dental coverage to qualified public employees and retirees, and their eligible dependents. Local employers must adopt a resolution to participate in the SHBP and its plans. The State Health Benefit Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 17.25 et.seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

Step Therapy — Step therapy encourages a trial of less costly first-line prescription drugs before the use of more costly second line agents. Second line agents are new medications that come on the market. The new medications are determined by the Food and Drug Administration (FDA) to be effective, but not more effective than the medications already on the market.

APPENDIX III

NOTICE OF PRIVACY PRACTICES TO ENROLLEES IN THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

EFFECTIVE DATE: APRIL 14, 2003.

Protected Health Information

The State Health Benefits Program (SHBP) is required by the federal Health Insurance Portability and Accountability Act (HIPAA) and State laws to maintain the privacy of any information that is created or maintained by the SHBP that relates to your past, present, or future physical or mental health. This Protected Health Information (PHI) includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the SHBP through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The SHBP is required by law to abide by the terms of this Notice. The SHBP reserves the right to change the terms of this Notice. If the SHBP makes material change to this Notice, a revised Notice will be sent.

SHBP Uses and Disclosures of PHI

The SHBP is permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the SHBP without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is illustrative only and not every use and disclosure in a category is listed.

- The SHBP may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The SHBP may use and disclose member PHI so that our Business Associates may pay claims from doctors, hospitals, and other providers.
- The SHBP receives PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.

- The SHBP and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The SHBP may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The SHBP may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The SHBP may use and disclose PHI for fraud and abuse detection.
- The SHBP may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the SHBP may use and disclose PHI in response to a court or administrative order as provided by law.
- The SHBP may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.
- The SHBP may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the SHBP will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the SHBP in the conduct of its business (our "Business Associates"). An authorization form may be obtained over the Internet at: *www.state.nj.us/treasury/pensions* or by sending an e-mail to: *hipaaform@treas.state.nj.us.* A member may revoke an authorization at any time.

When using or disclosing PHI, the SHBP will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The SHBP maintains physical, technical and procedural safeguards that comply with federal law regarding PHI.

Member Rights

Members of the SHBP have the following rights regarding their PHI:

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy of their PHI that the SHBP maintains in a designated record set which consists of all documentation relating to member enrollment and the SHBP's use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the SHBP amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The SHBP may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the SHBP; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures*:* Members have the right to receive an accounting of the instances in which the SHBP or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years or back to April 14, 2003, whichever period is shorter. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treatment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the SHBP place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The SHBP is not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Request Confidential Communications: The member has the right to request that the SHBP communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the SHBP to collect premiums and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Questions and Complaints

If you have questions or concerns, please contact the SHBP using the information listed at the end of this Notice.

If members think the SHBP may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the SHBP communicate with them in confi-

dence by alternative means or at an alternative location, they must submit their complaint in writing. To obtain a form for submitting a complaint, use the contact information found at the end of this Notice.

Members also may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The SHBP supports member rights to protect the privacy of PHI. It is your right to file a complaint with the SHBP or with the U.S. Department of Health and Human Services.

Contact Office:	The State Health Benefits Program—HIPAA Privacy Officer
Address:	State of New Jersey Department of the Treasury Division of Pensions and Benefits Bureau of Policy and Planning PO Box 295 Trenton, NJ 08625-0295
Fax:	(609) 341-3410
E-mail:	*hipaaform@treas.state.nj.us*

APPENDIX IV

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

ADDRESSES

Our Mailing Address is . . . . . .The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is . . . . . *www.state.nj.us/treasury/pensions/shbp.htm*

Our E-mail Address is . . . . . *.pensions.nj@treas.state.nj.us*

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Benefit Information Library/Fax on Demand . . . . . .(609) 777-1931
Office of Client Services . . . . . .(609) 292-7524
TDD Phone (Hearing Impaired) . . . . . .(609) 292-7718

Caremark - Member Services 1-866-881-5605

Horizon Blue Cross Blue Shield of New Jersey . . . . . .1-800-414-7427 (SHBP)

State Employee Advisory Service (EAS) . . . . . .(609) 292-8543

Rutgers University Personnel Counseling Service (EAP) . . . . . .(732) 932-7539

New Jersey State Police
Employee Advisory Program (EAP) . . . . . .(856) 234-5652
. . . . . .(908) 231-1077
. . . . . .(609) 633-3718
. . . . . .1-800-FOR-NJSP

University of Medicine and Dentistry of New Jersey (EAP) . . . . . .(973) 972-5429

New Jersey Department of Banking and Insurance

Individual Health Coverage Program Board 1-800-838-0935
Consumer Assistance for Health Insurance . . . . . .(609) 292-5316
(Press 2)

New Jersey Department of Human Services

Pharmaceutical Assistance to the Aged and Disabled (PAAD) 1-800-792-9745

New Jersey Department of Health and Senior Services

Division on Senior Affairs 1-800-792-8820
Insurance Counseling 1-800-792-8820
Independent Health Care Appeals Program . . . . . .(609) 633-0660

Centers for Medicare and Medicaid Services 1-800-Medicare
New Jersey Medicare - Part A 1-866-641-2007
New Jersey Medicare - Part B 1-800-462-9306

STATE HEALTH BENEFITS PROGRAM PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Employees and retirees can obtain copies of these publications by contacting their employers or by calling the Division. Our Benefit Information Library (BIL) is available 24 hours-a-day, seven days-a-week. If the items you require have a BIL number, dial (609) 777-1931, from a touch-tone phone, and enter the three-digit BIL selection number when instructed. After the recorded information leave your name, mailing address with ZIP Code, and Social Security number to have the publication or fact sheet mailed to you.

If the items you require have a Fax on Demand (FOD) number, you can have the publication or fact sheet automatically faxed to your fax machine. To use our Fax on Demand service, dial (609) 777-1931. Follow the instructions to access Fax on Demand and, when requested, enter the four-digit FOD selection number along with your fax number (area code and telephone).

Fact sheets and other publications are also available for viewing or downloading over the Internet at: *www.state.nj.us/treasury/pensions*

General Publications

State Health Benefits Program Summary Program Description booklet.

State Health Benefits Program Comparison Summary - Plan comparison chart. (State Employees - FOD #8251; Local Employees - BIL #250, FOD #8130; All Retirees - BIL #130, FOD #8130)

Benefit Information Library Catalog - A catalog of informational items available through the Benefit Information Library and Fax on Demand service. (FOD #8000)

SHBP Fact Sheets

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire.* (BIL #208) (FOD #8208)

Fact Sheet #23, *The State Health Benefits Program and Medicare Parts A & B for Retirees.* (BIL #134) (FOD #8134)

Fact Sheet #25, *Employer Responsibilities under COBRA.* (BIL #345) (FOD #8345)

Fact Sheet #26, *Health Benefits Options upon Termination of Employment.* (BIL #258) (FOD #8258)

Fact Sheet #30, *The Continuation of New Jersey State Health Benefits Program Coverage Under COBRA.* (BIL #254) (FOD #8254)

Fact Sheet #37, *SHBP Employee Dental Plans.* (BIL #256) (FOD #8256)

Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330 - PFRS & LEO.* (BIL #136) (FOD #8136)

Fact Sheet #51, *Continuing SHBP Coverage for Overage Children with Disabilities.* (BIL #259) (FOD #8259)

Fact Sheet #60, *Voluntary Furlough Program.* (FOD #8418)

Fact Sheet #66, *SHBP Coverage for State Part-Time Employees.*

Fact Sheet #69, *SHBP Coverage for State Intermittent Employees.*

Fact Sheet #71, *Benefits Under the Domestic Partnership Act.* (FOD #8419)

Fact Sheet #73, *Retiree Dental Expense Plan.* (FOD #8257)

SHBP Member Handbooks

SHBP NJ PLUS Member Handbook.

SHBP Traditional Plan Member Handbook.

SHBP HMO member handbooks are available from the individual HMOs (see *SHBP Summary Program Description* for contact information).

SHBP Employee Prescription Drug Plan Member Handbook.

SHBP Employee Dental Plans Member Handbook.

SHBP Retiree Dental Expense Plan Member Handbook.

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